agreement with Mr. Baines in dismissing as causative factors *Trichomonas vaginalis* infection with that of gonorrhoea and dysentery. I find, however, his conclusion that Reiter's disease and abacterial pyuria are variations on the same aetiological theme and that they are always "venereal" in nature much more difficult to accept. May I give as briefly as possible the main results from a fairly considerable experience with cases of this nature which passed through my department during service in the Middle East?

In 1941-2 the early cases of Reiter's disease admitted to my department were missed, since self-administration of sulphonamides was so common before reporting that smears and cultures, negative for the gonococcus, in cases of urethritis, arthritis, and conjunctivitis were suspect and certainly not sufficient to suggest the discovery of a new disease. Two cases, however, occurred which convinced me (and I was difficult to convince) that here indeed was a syndrome without a venereal history in some cases. From that time cases presenting this triad were investigated not only in my department but in the associated dysentery and ophthalmic sections of the hospital with the following results:

- (1) The conjunctivitis may precede the urethritis in some cases.
- (2) The conjunctivitis may be so mild that only a very slight injection of the conjunctival vessels is present. In this connexion it was found that slit-lamp examination revealed tiny bead-like lesions deep in the lower limbus of the cornea which on clearing left minute striae. One case, presenting urethritis and arthritis but who gave a history of conjunctivitis a few weeks previously, showed these tell-tale scars, and it is suggested that this sign is looked for in future cases. Perhaps conjunctivitis indicating inflammation of the conjunctiva is not therefore a true description of the "red eye" in Reiter's disease.
- (3) Prolonged search among literally hundreds of cases of dysentery in the hospital failed to reveal a true case of the syndrome.
- (4) Treatment had no effect on any of the triad. Recovery was the rule, but was often delayed for a period of months.
- (5) Scanty Gram-positive diplococci were found on a few occasions, but cultures were negative. In most cases no organisms were found.
- (6) The complete success with arsenic in abacterial pyuria in my opinion placed this syndrome in its own category and suggests that the infecting organism will be found to be as highly organized at least as the spirillum, from our knowledge of the therapeutic effects of arsenic in other infections.

Finally, although clinical impression can only be subsidiary as evidence, I came to the conclusion (a) that virus infection of "swimming-bath conjunctivitis" and virus cervicitis in the female were both possible sources of infection in cases of Reiter's disease; (b) that usually it is a systemic infection with local signs dependent on local tissue peculiarities. And in this connexion I have made a tentative suggestion, as yet unpublished, of yet another factor which may play a part not only in cases of this nature but also in the systemic complications of gonorrhoeal infection.—I am etc.,

London, W.1.

F. L. LYDON.

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- ¹ Baines, G. H. (1947). *British Medical Journal*, 2, 605.
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Unusual Pregnancy

SIR,—The following case may be of interest to you.

CASE REPORT

A girl, a primipara aged 27, consulted us in early January of this year complaining that she was losing blood per vaginam. On examination it was found that she was three months pregnant, the last menstrual period being on Nov. 17, 1946. The uterus could be felt just about level with the pubis; the cervix was soft, and she was losing blood. She was put to bed and given 5 mg. of "luto-cyclin." Four days later she aborted a foetus, complete in its sac, about 1 1/2 in. (1.25 cm.) long. She was kept in bed for a further six days, and, her lochia having dried up completely, she was allowed to get up. Three days later she was called away urgently to nurse her mother with pneumonia, and on her return six weeks later she came to see me for a post-natal examination. She had been very well during the time she had been away, had done a lot of heavy work, and was feeling very fit.

I was somewhat surprised to find the uterus up to the umbilicus, and her Asheim-Zondek test was positive, so I hastily rebooked her for her maternity care and proceeded with a routine antenatal examination.

On July 25 she was delivered with ease of a 5 1/2-lb. (2.5-kg.) male child, and ten minutes later the placenta appeared at the vaginal orifice. No further detachment took place, and after two hours her condition began to deteriorate. She was given a general anaes-

thetic, and on manual examination it was found that about three-quarters of the placenta was in the vagina. The uterus was contracted down hard, and under very deep anaesthesia further relaxation was obtained to get the hand into the body, and it was found that there was a thick fibrous adhesion (1/2 in. thick) between the placenta and the uterine wall on the right-hand side of the vault. This was with difficulty divided and the placenta was delivered. The girl's puerperium was uneventful.

It would appear that this girl aborted one foetus during pregnancy and successfully carried the second baby to within a fortnight of her term. At the side of the first foetal implantation adhesion occurred between the remaining child's placenta and the uterine wall, possibly in a clot left by the abortion of the first foetus. In view of the fact that the second child went almost to term, one cannot suppose that this is a case of superfecundation. Neither my partner nor I have personally seen this sequence of events before, but it would appear to have followed a logical course.—I am, etc.,

Ruskington, Lincs.

T. SMALLHORN.

Retained Placenta

SIR,—A woman who had just been delivered of her second child in spite of having good uterine contractions every 3-4 minutes was still undelivered of her placenta at the end of 35 minutes. There had been no bleeding. She was then placed in the squatting position over a bedpan, and the placenta was delivered with the next contraction—coincidence, perhaps, but worth trying as the first measure in all patients who are well enough to co-operate.—I am, etc.,

Winfrith, Dorset.

P. R. BOUCHER.

Myocarditis of Pregnancy

SIR,—I had recently what appears to me to be a case which would be interesting for publication. The following briefly are the facts of the case.

CASE RECORD

A married woman aged 34 years was admitted to the County Hospital, Roscommon, on Oct. 11, 1947, having a history of three months' pregnancy, but bleeding on and off for a week prior to admission to hospital. On examination after admission she had a fairly heavy dirty vaginal discharge. She was thin and pale in appearance and she said she did not feel well. P.V. on admission: The os was sufficiently dilated to admit one finger. The uterus was about 2-3 months in size and was soft and flabby. On the examining finger was a mixture of thick pus and blood. A culture of this material produced a predominant *Staphylococcus aureus*.

She had no pyrexia. Her pulse, however, was very irregular. At the wrist there were two beats occurring regularly together within a very short space of each other. After these there was an evenly spaced two beats, more like normal heart beats, and again after these the two beats occurring quickly together. The pulse went on in this regular irregular fashion. At the apex the heart beats were of the same pattern as the beats at the wrist—namely, two normal heart sounds, a long pause, then two beats occurring quickly together, with a long pause and again two normal beats.

An electrocardiogram taken on Oct. 13, of which I enclose lead III (Fig. 1), shows what I take to be two ventricular extrasystoles occurring regularly together, interspaced between two normal PQRS complexes. The other leads (I and II) showed similar abnormality.

It was decided not to interfere with the uterine condition but to treat her conservatively. She gradually improved, her discharge ceased, and it was noted on Oct. 23 that her pulse was of normal rhythm. I took a cardiogram on Oct. 24—that is, twelve days after

FIG. 1.—Electrocardiogram (lead III) taken on Oct. 13, 1947.

FIG. 2.—Electrocardiogram (lead III) taken on Oct. 24, 1947.

admission; I enclose lead III of this cardiogram (Fig. 2). It shows the heart beating regularly and normally without any ectopic beats. Leads I and II were also normal. She felt well and was discharged home on Oct. 26.

These, Sir, are briefly the findings in this case, and I consider it rare and interesting for the following reasons. (1) The heart condition seems to have been a toxic myocarditis causing ectopic ventricular beats. (2) The toxæmia was mild, causing no temperature or tachycardia. (3) In my library I cannot find any cardiograms like the tracings found in this case. (4) The clinically alarming condition of her heart and the rapidity with which it cleared up.—I am, etc.,

Roscommon, Eire.

JOHN J. WALLS.

Obstetric Emergency Service

SIR,—Mr. Frank Stabler's excellent paper on the Newcastle-upon-Tyne obstetric emergency service (Nov. 29, p. 878) gives me an opportunity to make a point of which I became convinced as an obstetric H.S. and the value of which I have since had a chance to confirm in general practice. This is that the general practitioner's obstetric bag should include either saline or plasma and a giving set. If he is to be called by the midwife in emergency he should at least bring these simple requirements; in this way he may very well save some of those cases which the "flying squad" admittedly cannot reach in time. He can put up a drip before undertaking manual removal of the placenta—a precaution which I find gives considerably increased confidence. Should the flying squad be called they arrive to find the transfusion arrangements ready set up and can the more quickly continue with any obstetric manipulations that may be necessary.

I would suggest that the regional transfusion officers might organize the supply and turnover of saline and standard giving sets to practitioners. After all, since the war there must be very few practitioners under the age of 50 unfamiliar with simple transfusion apparatus. The supply of plasma might, however, be impracticable. Such apparatus will also come in useful in pit accidents, and its availability on the spot has saved the life of one of my fellow practitioner's patients in this area.—I am, etc.,

Morpeth, Northumberland.

R. P. ROBERTSON.

SIR,—If penicillin resistance is to raise its hydra head, manual removal of placenta may well regain pride of place as the most dangerous operation in midwifery. One pictures the modern scene. By the time Mr. F. Stabler has scrubbed up and donned a pair of dry sterile gloves (another pair, of the right size, lying ready in case he tears the first), sister has "wooded" the patient from navel to knees, a sterile towel is on the abdomen, another occludes the rectum, the vagina has been swabbed with flavine, and another expert has anaesthetized the patient. It is probable that in these circumstances running in and out of the uterus as advised may not end in disaster.

But what of the occasional obstetrician in the back of beyond who knows that Mr. Stabler cannot reach him and the blanched woman under two hours? Hastily scrubbing up, he pours pure "dettol" on his hands and "washes" till tacky, anxiously eyeing the while inexpert chloroform dripping at one end and red blood at the other. Introducing a hand he separates the placenta all round and delivers it—*horribile dictu*—by pulling on the cord, and *then* feels round for debris. Obviously the uterus cannot invert with the hand in the fundus; the membranes are not more likely to be torn than by fingers scratching about inside; and only *one* introduction is required. One would of course not dare to say this had one not heard it advocated by a most distinguished London gynaecologist.—I am, etc.,

London, E.4.

FREDERIC SANDERS.

"Unjustified" Use of d-Tubocurarine Chloride

SIR,—I hesitate, as an obstetrician, to enter into this correspondence between two such experts, but as I understand it the uses of curare in this respect are that (a) it greatly diminishes the tendency to spasm, making intubation, if necessary, easier; (b) it enables the entire anaesthetic to be conducted on an exceptionally light plane so that the infant, not being "anaesthetized," cries almost as soon as the head is born and the patient almost before leaving the theatre is becoming conscious; (c) it "potentiates" the action of the barbiturate, thereby lessening the required dose. These reasons Dr. T. Cecil Gray has already ably expounded. Dr. A. H. Galley (Nov. 22, p. 840) has

scarcely viewed the matter from the standpoint of the obstetrician when he states that "the only possible reason for administering curare preparations to caesarean sections must be for its effect in relaxing the tone of the abdominal musculature." In point of fact, while a fair degree of relaxation is obviously desirable in the initial stages of the operation, it is clearly not asked for with the same urgency as in general surgical procedures in the upper abdomen.

In so far as uterine tone is said to be enhanced by this type of anaesthesia, the problems in pure physics inherent in the contracting uterus simplex at the onset of labour are sufficiently complex as surely to make it unlikely that one may justifiably cite a simple relationship between "kemithal"—cyclopropane anaesthesia and the "eyeful of liquor" which incommoded the present P.R.C.O.G. The incident was disturbing but did not necessarily prove very much, and with optimum conditions such an incident could, I imagine, be repeated quite easily under local anaesthesia. The essential point which I would make is that as an obstetrician one bears a heavy responsibility, not for one life but for two. The mother is frequently ill prepared for a major surgical procedure in comparison with what her state of preparedness would have been for most procedures in general surgery, and the influence particularly of the older types of inhalation anaesthesia on the foetus is too well known to need emphasis. The technique that my colleague Dr. Gray described so well in the *Journal* of April 5 (p. 444), and with which I have now had a fair experience in collaboration with him and other expert anaesthetists, seems to me to offer the obstetrician a few more significant advantages than a little added relaxation of the abdominal musculature, which in any case can often be done without in the initial phase of the operation.—I am, etc.,

Liverpool.

H. VINCENT CORBETT.

Diabetes Insipidus and Hyperostosis Frontalis

SIR,—I have read with great interest Prof. G. Marañón's article about diabetes insipidus and uterine atony (Nov. 15, p. 769), but I am surprised that he does not discuss the possible significance of the slight frontal hyperostosis disclosed by the radiograph. Could that hyperostosis not be the "non-malignant non-progressive lesion of small size" for which he looks? It is known that patients with hyperostosis frontalis interna have frequently cerebral symptoms and signs and particularly those pointing to the hypothalamic-pituitary region.—I am, etc.,

Harrow Weald, Middlesex.

A. LETCHNER.

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Oxytocic Action of Ascorbic Acid

SIR,—Prof. Chassar Moir emphasized^{1,2} the proper use of pituitary extract and ergometrine during and after labour. Dale's³ discovery and Hofbauer's⁴ practical application of the remarkable physiological action of posterior-pituitary extract on the gravid uterus, and Dudley and Moir's⁵ isolation of ergometrine, are corner-stones in the advance of conservative midwifery.

The dangers of employing pituitary extract for induction and acceleration of labour have been stressed repeatedly. Chassar Moir's golden rules for the use of standardized pituitary preparations should be strictly observed by all who practise midwifery. With considerable interest I have therefore collected experience about the use of ascorbic acid as an oxytocic agent in labour, having had in mind the disadvantages of pituitary-extract preparations in the first and second stage of labour. My observations, which are based on several hundred deliveries, confirm the views of Kappeli,⁶ of the gynaecological university clinic in Berne, that ascorbic acid has a distinct influence on uterine contractility.

I found that the time of employment is chiefly the dilatation period. Contractions must be established. It has, therefore, no effect on an inactive uterus. For induction of labour I found it unsuccessful. Ascorbic acid is used in the first stage, cervix 2-3 fingers wide, when uterine contractions are less than one in three minutes and weak. It is administered preferably by mouth, 100 mg. of ascorbic acid for three doses at half-hourly intervals. If there is no effect the drug can be given in three 6-hourly courses within 24 hours. A 1-min. (0.06-ml.) dose of